F O U N D A T I O N S F O R T H E F U T U R E

A REPORT OF THE WORKING GROUP

ON CHILD AND YOUTH MENTAL HEALTH SERVICES

PREPARED FOR
THE FEDERAL/PROVINCIAL/TERRITORIAL
ADVISORY COMMITTEE ON MENTAL HEALTH

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To the Reader:

Foundations for the Future is the first comprehensive report on the mental health of children and youth in Canada. The work was commissioned by the Federal/Provincial/Territorial Advisory Committee on Mental Health and prepared by a Working Group which was established for the purpose.

Foundations for the Future comprises a unique blend of the historical developments, current status and future directions of mental health services for children and youth in Canada. The report provides the basis for a greater understanding of the mental health needs of youngsters, describes the services which are available to meet those needs, and lays the foundation for future development.

Four major themes emerged during the preparation of the report. Each theme represents a critical direction for the future development of mental health services for children and youth. The four themes are:

* the increasing importance of mental health promotion;
* the development of partnerships;
* improved access to specialized services; and
* innovation and excellence in addressing the needs of children, youth and families.

Each Province and Territory in Canada has developed a unique mental health program to serve children and youth. In British Columbia, the last five years has seen a significant increase in the priority afforded to mental health services for children and youth and an increase in the commitment to working together with other Ministries and community agencies on their behalf.

Anyone who wishes more information about services in British Columbia, or who is interested in commenting on the report Foundations for the Future, may contact the local Mental Health Centre, Greater Vancouver Mental Health Services, Burnaby Psychiatric Services, or write to:

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1.0
INTRODUCTION AND WORKING GROUP MANDATE

1.1 Section Overview

This section reviews the mandate given to the Federal Working Group On The Mental Health Of Children And Youth by the Advisory Committee on Mental Health. Rationale for the working group's activity, objectives and priority issues are presented.

1.2 Rationale For The Working Group

Children and youth under the age of nineteen constitute approximately 30 percent of the total population of Canada; however, they have not been a major focus of mental health programs. Historically, mental health policies and programs have largely focused on the treatment of the adult population; consequently, services for the young have developed slowly and as an adjunct to programs for adults.

It is increasingly recognized in the field that mental health issues affecting children and youth have to be addressed on a priority basis. An examination of policy and program options for services to children and youth corresponds to the increased need for services and the need to give higher priority to children and youth who are Canada's future. Given the growing recognition that most adult mental health problems have their antecedents in earlier identifiable childhood problems, attention to prevention activities becomes a critically important future investment initiative.

1.3 Objectives Of The Working Group

As stated in the original Terms of Reference (ACMH Secretariat, April 1986), the Working Group on the Mental Health of Children and Youth was given three primary objectives. The first objective was to consider and advise the Advisory Committee on Mental Health on policy, designed to address conditions of psychiatric and psychological distress, disorder, and disability in the children and youth of Canada.

The second objective was to assist in the development of specific programs and resource materials on children's and youth's mental health, and on strategies and interventions such as would be useful to mental health workers, policy makers and program directors responsible for provincial and other child and youth mental health programs. Finally, the third objective was to

provide opportunities, at the national level, for the exchange of information on topics of particular interest to mental health workers, policy makers and program directors.

In summary, the Working Group was mandated to review the existing mental health status of Canadian children and youth, the existing status of mental health services for this population, and to identify critical issues in service provision and the integrated delivery of these. Based on their findings, the Working Group was asked to recommend services that would meet the mental health needs of Canadian children, youth and their families and promote their mental well-being.

1.4 Priority Issues

Recently, public attention on the mental health needs of the young has been focused by reports of increases in child and adolescent suicide, drug and alcohol abuse, and child abuse including sexual abuse. The original mandate given to the working group was to focus particular attention on these three areas of specific concern as a means to identify practical models of service delivery. Looking thoughtfully at their task, the Working Group came to realize that these high profile areas of public concern serve to emphasize general problems in the provision of all mental health services for children and youth. Furthermore, a review of recent evidence and current thinking indicated that there is a great deal of overlap among these problems, as well as between these and other problems of public concern. This suggested a commonality in causation, and thus to concentrate on selected areas to the exclusion of others (e.g. conduct disorders and emotional disorders which represent the greatest aggregate risk groups of mental health problems, domestic violence, etc.) would result in an "out of context" examination, and could lead to erroneous conclusions.

Evolving from these general problems are priority issues in child and youth mental health services which must be addressed by the federal and provincial/territorial governments. The first of these issues is the need for planning and coordination of a broadly based children's services network. This network is essential to provide for the special needs of young people, and would rely heavily upon the integration of specialized programs with community programs and resources. The network must also include the development of a viable non-government network to provide children's mental health services within Canadian communities.

The second issue is the need for the integration of hospital and community mental health systems. Key elements to a successful integration begins at the practitioner level. That is, there is a need for increased cooperation between private practitioners (family physicians, psychologists, psychiatrists, social workers) and mental health centre personnel. Related to the need for increased professional cooperation is the need to develop stronger links between acute care hospitals and community programs These links would form the basis for functional partnerships within the community as a whole and, as such, would need to be formalized (e.g. through contractual agreements or working protocols). A final need for a successful integration of all mental health systems is to promote and encourage the involvement of families and consumers as key participants in the services partnership. This last point is important to emphasize from the perspective that the role of families and consumers is rapidly shifting from traditional passivity to one of active and pro-active partnership with the service systems involved.

The third priority issue which must be addressed by the federal and provincial/territorial governments is the need for proactive planning to develop preventive and early intervention services. A critical element of preventive and early intervention services would include the development of close links with public health programs. Public Health has a structure in place to reach nearly all children and families in Canada. As such, Public Health represents one promising means by which a second need, increased clinical consultation services for very young disturbed children, may be facilitated and increased. Additionally, there is a need for the development of special target programs in conjunction with community interest groups and agencies as well as an increase in mental health promotion with an emphasis on the family.

Finally, the immediacy of services to children and youth who require specific attention must be addressed. Children's services should be given as immediate responses. Crises and growth and developmental issues require immediate attention. Specific examples include, but are not limited to, a number of groups and/or situations. For example, parent/teen conflict has a great impact on all service delivery systems (e.g. mental health, social services, schools). Adolescent suicide is the second leading cause of death, and is still on the increase (Dyck, 1988: Suicide Prevention For The Young, a paper prepared for the Working Group). Youth lifestyle issues, such as premature sexuality and alcohol and drug abuse are also often the focus of underlying mental health concerns not only in terms of

the individual's immediate circumstance, but also in terms of poor prognosis for adult functioning. Finally, the confused status of 16-19 year old youths in transition from child to adult services often leads to many problems in access to services, as well as abuse of services.

1.5 The Foundations For The Future

Given its original mandate, the Federal Working Group embarked on its task, enlisting expertise from across Canada. In fulfilling its original objectives, the group recognized that there were many issues involved in and influencing the current mental health status and future mental health needs of Canada's children and youth.

The sections that follow present a summary of the Working Group's findings. Each section contains central ideas and directions which, taken together, form the foundation for change and innovation in the future. This foundation is represented through the presentation of four major building blocks at the end of this report, each presented broadly enough to accommodate the wide inter-provincial diversity in mental health services. These four building blocks, or major directions for action and changes are:

- MENTAL HEALTH PROMOTION
- PARTNERSHIPS
- ACCESS
- INNOVATION & EXCELLENCE

What is required now is the further development of the concepts and ideas put forth by the Working Group. What is needed now is the development of a comprehensive national strategy to implement mental health services to meet the specific and unique mental health needs of our children and youth. It is a need whose time has come. The need to act now exists not only because of current inadequacies and fragmentations of services, but also because the foundations for implementation planning and consultation, as represented by this report, have been put into place.

2.0
GUIDING PRINCIPLES

2.1 Section Overview

The purpose of this section is to present a number of fundamental and guiding principles important for future planning of comprehensive mental health services and programs for Canadian children, youth and their families. These principles are derived from the recently proclaimed United Nations Convention on the Rights of the Child, the Constitution of the World Health Organization, and Admittance Restricted: The Status of Children in Canadian Society (Canadian Council on Children and Youth, 1978).

2.2 Understanding Health And Health Care

The definition of health for the purpose of this report is taken from the Constitution of the World Health Organization, and has previously been adopted by Mental Health For Canadians: Striking a Balance): "Health is a state of complete physical, mental and social well-being and not merely the absence of disease.... Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential..." Health is a dynamic relationship between the person and his/her environment. Concern about health and health care resources is the responsibility of each person in society. The health of children and youth is of critical importance as it represents an investment in the future health of Canada as they become adults.

In this report, health care is considered from three broad levels of application: prevention, treatment and rehabilitation.

1. Prevention: aims to reduce the incidence of disease or dysfunction in a population through modifying stressful environments and strengthening the ability of the individual to cope. Prevention involves the promotion and maintenance of good health through education, attention to adequate standards for basic needs, and specific protection against known risks.

2. Treatment: aims to reduce the prevalence (number of existing cases) of a disorder or dysfunction and includes early diagnosis, intervention and treatment.

3. Rehabilitation: aims at reducing the after effects of disorder or dysfunction, and involves the provision of services for re-training and rehabilitation to ensure maximum use of remaining capacities by the individual.

2.3 The Rights Of Children And Youth

Currently, and for the most part in Canada, children are served by mental health systems evolved from the historical need to provide for the involuntary care of mentally disordered adults. As a result, children's and youth services have developed as adjuncts to the service system which has as its priority the needs of the adult chronically mentally ill. Recently, however, Canada has joined an international thrust which carries far reaching implications for changing this unsatisfactory state of affairs.

In late 1989, Canada co-presented the United Nations Convention on the Rights of the Child. As an international instrument the Convention, after signing, is binding, requiring each individual State (e.g. Canada) to accede to ratify it, thereby signifying their intention to comply with the provisions and obligations the Convention contains.

Two articles of the Convention are particularly relevant to children's and youth's mental health and mental health services. First, Article 24 of the Convention recognizes the right of the child to the:

> "...enjoyment of the highest obtainable standard of health and to facilities for the treatment of illness and rehabilitation of health...(and) that no child is deprived of his or her right of access to such health care services."

Second, Article 12 of the Convention recognizes the right of the child to a more active and assertive role by assuring:

> "...the child who is capable of forming his or her own views the right to express those views freely in all matters...the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child."

It is through instruments such as the United Nations Convention that society recognizes problems and proposes solutions. Without the attention of the formal processes of society, the mental health needs of youngsters are unlikely to be met except in a partial and insufficient manner. It is within this context that four conceptual principles are proposed which form the foundation for age-appropriate mental health policy for children and youth. The four principles, which are adopted from Admittance Restricted: The Status of Children in Canadian Society (Canadian Council on Children and Youth, 1978), are as follows:

1. Human rights are indivisible: they are not to be parceled out to different segments of society at different times and under different circumstances. However, rights are linked to obligations and social sanctions. Thus children's rights are generally not exercised by children directly, but indirectly through others such as parents, schools, courts and other agencies;

2. Support for the family is the single most important manner in which society can see to the rights of children. Change in the role of the family has been the most significant social change over the last few decades. It is because of these changes to the family that the over-riding importance of appropriate children's mental health policy must be considered at this time;

3. Equality of opportunity for children can best be achieved in Canadian society through social policy which supports parental responsibility. Families are not capable of being equal providers and, consequently, many youngsters are disadvantaged greatly. Society's role is to support families to ensure equalization of social opportunity for all children;

4. Care must be taken to ensure that the interests of the child remain uppermost when the matter of individual rights of a child is the focus. Decisions made by others on behalf of dependent children require a delicate balance of the child's individual interest with those trusted with the care of the child.

2.4 Responsibility For Children In The Health Care System

Responsibility for the mental health and well-being of children and youth is shared by children themselves, by their families and by society at large. Children are dependent upon the family and society for recognition of their health needs, for education concerning good health practices, and for the provision of necessary care. However, as children mature they have a gradually increasing personal responsibility for their health. The family provides the primary environment in which the health of the young is generated and maintained, and through which the young eventually become independent in their own health care. The family also provides the focus through which the health care needs of the young are identified and the necessary services provided. Access to health care is to a large extent determined by existing family and societal patterns.

It is a fundamental belief in our society that children are the responsibility of their parents and that, through families, children receive the nurture they require. Society ensures the health of the young by strengthening the capacity of the family to provide for children. Generally, society does not provide resources or services directly to children without parental involvement and consent.

If parents are unable to care for their child or neglect to do so, society can intervene to ensure that the child's needs are met. In this manner, society may provide special services to assist parents to meet the extra burden of children with special needs (e.g. the handicapped and chronically ill). In instances where parents refuse necessary services or fail to provide for their child, society can protect the child's interests through legal action to remove the child from the parents and to ensure that the child's needs are met through appropriate care or treatment.

2.5 Basic Principles Underlying Mental Health Programs For Children And Youth

Based on its deliberations, the Working Group recognizes four basic principles essential for the planning, development and implementation of mental health programs for children and youth. These four principles are as follows:

1. The family is central to the provision of universal health for children and youth; consequently, the first priority must be afforded those aspects of health policy which strengthen the capacity of families to provide for their children;

2. A distinct emphasis on the particular health needs of children and youth is essential to ensure that their needs are recognized, articulated, and met within the overall health services organization;

3. The traditional emphasis on curing disease in institutional settings is insufficient, and must be balanced with more active community-based programs and initiatives. Of particular note is the need to reinforce and expand multiplicative models of service provision whereby a few specialists can actively support the interventions of many more persons in the community (e.g. teachers, child care centre staff, public health personnel, etc.) who are in direct contact with children and families;

4. Health and access to appropriate services are possible only if there are more proactive programs available for those at risk and for those who currently do not avail themselves of existing services.

3.0
THE MEANING OF MENTAL HEALTH CARE FOR CHILDREN AND YOUTH

3.1 Section Overview

The purpose of this section is to present a framework, based on Mental Health For Canadians: Striking a Balance (1988), for the understanding of the meaning of mental health for children and youth. As a means to understanding mental health, this section presents a schematic model of the relationship between mental disorder and mental health problems. Additional material for this section is based on Child, Adolescent and Family Mental Health (New Zealand Department of Health, 1989), and The Health of Canada's Children: A Canadian Institute of Child Health (CICH) Profile (1989).

3.2 Distinctions Between Mental Disorder And Mental Health Problems

As stated in Striking a Balance, a mental disorder is defined as "...a recognized, medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities." (p.8). On the other hand, a mental health problem is defined as "...a disruption in the interactions between the individual, the group and the environment." Mental health problems may result from factors within the individual (e.g. physical or mental illness, inadequate coping skills), or external factors such as the existence of harsh or unfavorable environmental conditions, unjust social structures, or tensions within the family or community. The crucial point is that mental disorder is never the only factor determining mental health. Rather, it is a single element within a much larger set of interconnected factors.

3.3 Relationship Between Mental Disorder And Mental Health Problems

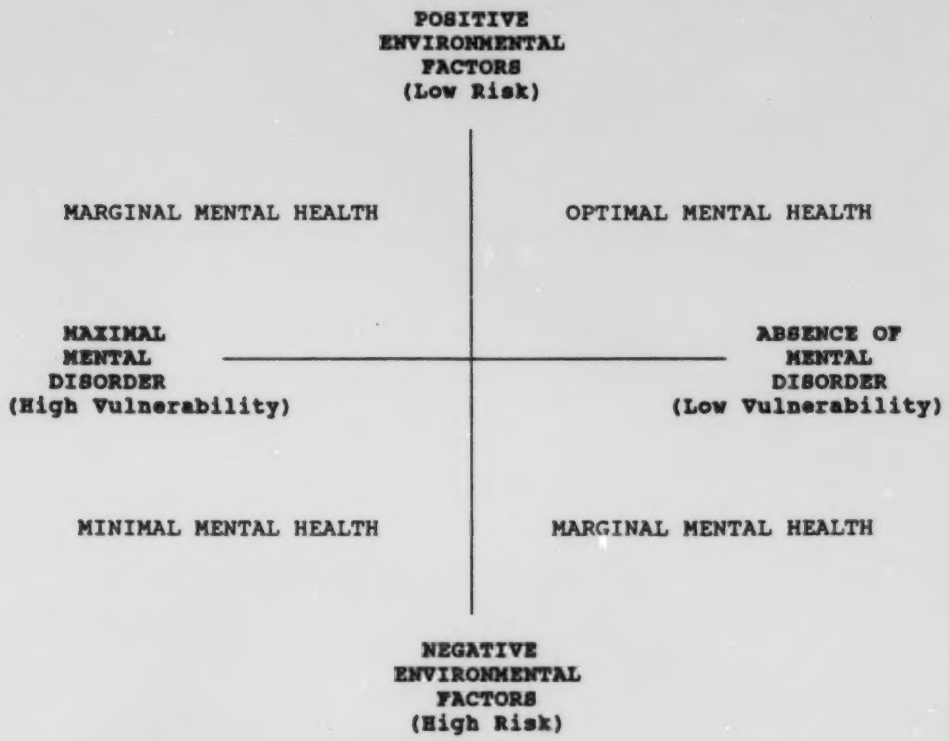
As defined in the preceding section, mental disorder may be represented by a continuum. Maximal Mental Disorder represents one end of the mental disorder continuum, and is defined as the greatest severity, frequency and range of psychiatric symptoms. The other end of the mental disorder continuum is represented by Absence of Mental Disorder, defined as freedom from psychiatric symptoms.

As well, mental health problems may also be represented by a continuum. Positive Environmental Factors represents one end of

the mental health continuum, as is functionally defined as individual, group and environmental factors working together effectively. Negative Environmental Factors represents the other end of the mental health continuum, and is functionally defined as individual, group and environmental factors working in conflict.

The dynamic relationship between environmental factors related to mental health and mental disorder is illustrated below as an intersection of the two continua. The result of the interaction of environmental factors and mental disorder is the mental health status of the child. Again, the critical point to be made via this illustration is that neither mental disorder factors nor negative environmental factors alone account for the mental health status of children and youth. Rather, the mental health status of children and youth is a dynamic interaction between vulnerability (mental disorder) and risk (environmental factors).

A Dynamic Relationship Between
Mental Disorder (Vulnerability) and Environmental Factors (Risk)


POSITIVE ENVIRONMENTAL FACTORS (Low Risk)
MARGINAL MENTAL HEALTH
OPTIMAL MENTAL HEALTH
MAXIMAL MENTAL DISORDER (High Vulnerability)
ABSENCE OF MENTAL DISORDER (Low Vulnerability)
MINIMAL MENTAL HEALTH
MARGINAL MENTAL HEALTH
NEGATIVE ENVIRONMENTAL FACTORS (High Risk)

3.4 Risk Factors Influencing The Development Of Mental Health Problems

In the preceding section, reference was made to negative internal factors (i.e. illness, coping ability) and negative external factors (e.g. social structures, family dysfunction, community tensions) which can influence the development of mental health problems in children and youth. A more specific delineation of the major factors involved in mental health and mental health problems of Canadian children and youth follows. Selected Canadian demographic data is included where available to provide indications of the degree of risk to Canadian children and youth for the development of mental health problems.

Relationship Factors. The formation and maturation of close relationship bonds is a critical task of child and adolescent development. When there is a failure to develop appropriate attachments, or where there is disruption of these relationships through separation, death or family dissolution, mental health problems may result:

- The divorce rate in Canada has increased dramatically; over 78,000 Canadian marriages ended in divorce in 1986, and 51% of these divorces involved children;

- 13% of all Canadian families with children in 1986 were headed by a single parent (10% by single mothers).

Children are at particularly high risk for mental health problems when there are distortions in relationships such as through physical or emotional neglect, or through physical, sexual or emotional abuse:

- 9% of female and 12% of male Canadian children under the age of 7 years are reportedly sexually abused;

- 37% of female and 36% of male Canadian children under the age of 15 years are reportedly sexually abused.

Emotional Factors. Children have a rich inner world of feelings and emotions which often is in contrast to the expectations of family and society and, from a developmental perspective, is difficult if not impossible for the child to control. Problems can arise when these feelings and emotions become overwhelming and manifest in excessive or prolonged fears, sadness, irrationality, anger, and unacceptable behaviour:

- In 1983, over 14,000 Canadian children were admitted to psychiatric or general hospitals specifically for mental health reasons.

Cultural Factors. Cultural attitudes, beliefs and values determine thinking feeling and action. When the cultural beliefs of children are thwarted or challenged by minority/majority cultural interchanges, problems of an anti-social nature can often arise, The ethnic composition of Canada has changed substantially:

- In 1986, 1 in 6 Canadians were born outside of Canada;

- In 1986, 1 in 10 Canadian households spoke a language other than French or English.

Intellectual and Educational Factors. Level of intellectual aptitude and characteristic styles of thinking are strong influences on children and youth behaviors and their adjustment to family, school, community and society. Risk for behavioral problems, poor social adjustment and lower coping skills increases with increased disability. As well, society rewards educational achievements, and success or failure contributes to how children and adolescents value or devalue themselves. Negative self valuation can play an influential role in the manifestation of mental health problems.

Physical Factors. Physical and sensory development, abnormalities, stigmata or medical problems all influence the mental health of children and youth. Children with developmental delays, brain damage, chronic disease, sensory disorders, etc., are at increased risk for maladjustment to society's expectations and demands.

Socio-Economic Factors. Many Canadian families have so few material resources that children are often also deprived of love, experience, intellectual stimulation, educational opportunity, and meaningful human relationships beyond basic survival. Poor housing, excessive mobility, urban over crowding, cultural impoverishment, rapid social change and high unemployment can all contribute to mental health problems of Canadian children and families:

- In 1986 1 in 5 Canadian children were living in poverty;

- Risk of psychiatric disorder is twice as high for families on welfare than for other families in Canada.

In addition to mental disorder and environmental factors, developmental factors also play a significant role in the mental health of children and youth. While developmental factors are not represented as a third dimension on the mental health continuum presented in the illustration **per se**, it is essential to be aware of the relationship between childhood problems and future functioning as an adult. That is, many children do not "grow out of a problem" as is often believed. Rather, they grow out of the childhood symptoms while the underlying problems remain into adulthood. Consequently, the enhancement of positive early experiences, as well as prevention and early intervention during childhood are critical for the development of healthy underpinnings of adult mental health.

3.5 Components of the Children's Services System

Throughout this report, the terms "Universal", "Targeted", and "Designated" are used to describe structural components of the total children's mental health services system from the user's (i.e. children, youth and their families) perspective. In essence, the overall structure represents a three-tiered model based on the situation or placement of the user, and mode of access by the user, rather than on structural or functional characteristics of the services systems and/or service providers. It is important to note that the model is not one of linear movement by the user; that is, a child/family could participate in more than one tier at any given time (i.e. go to school and receive treatment at a Child Guidance Clinic). In using these terms, the following structure was followed:

TIER 1. Universal Access Services (UAS) is used to refer to all services which occur essentially universally in the natural environment of Canadian children and families, and which influence the mental health of children and youth via the promotion of well-being and family independence. Two systematic examples of Universal Access Services to Canadian society are schools and public health.

TIER 2. Targeted Access Services (TAS) is used to refer to elective (from the user's perspective) mental health services providing more formalized and specialized mental health promotion and prevention of mental disorder/ problems, as well as assessment, diagnosis and treatment of mental health problems and disorders. Targeted Access Services would include Child Guidance Clinics, family support systems and programs, and voluntary in-patient programs.

TIER 3. Designated Access Services (DAS) is used to refer to segregated (from the user's perspective) systems and programs into which children and youth are 'admitted' involuntarily based on the need for their's and others' protection, and which can and do provide mental health services. Primary examples of Designated Access Services are mental health institutions designated under Mental Health Acts accessed via involuntary admission, the Child Welfare system, and the Young Offenders system.

In discussions of the total children's mental health system and relevant issues, reference is made to 'formal Mental Health Services'. Formal Mental Health Services are defined as Targeted and Designated services which have a primary responsibility to provide mental health services and, as such, include hospitals, institutions and community child guidance and mental health clinics.

3.6 Implications For Future Planning

Clearly, the mental health status of children and youth is influenced by two primary factors: the vulnerability to mental disorder, and environmental risks. Efforts to improve the mental health status of children and youth must reflect priority attention to each continuum, while at the same time recognizing the impact of developmental factors on both continua.

To improve the mental health of children and youth, policies and strategies are required which support the promotion and protection of mental health within the context of environmental factors. At the same time, policies and strategies are required which support the prevention, treatment and rehabilitation of mental disorder. Most importantly, all of these policies and strategies must be coordinated and integrated between and among all three tiers of the mental health system which occur in the natural communities of Canadian children and youth.

4.0
CURRENT MENTAL HEALTH STATUS OF CANADIAN CHILDREN AND YOUTH

4.1 Section Overview

The purpose of this section is to briefly review the prevalence of mental disorder and dysfunction among children and youth. As well, this section will discuss known vulnerabilities and risk factors associated with children's and youth's mental health. Many of the findings reported in this section are based on the review papers Mental Health Status Of Children In Canada (Krzanowska, 1988) and Ranges Of Rates Of Prevalence Of Childhood Mental Illness (Renney, 1988), prepared for the Working Group. Other findings are based on the Ontario Child Health Study: Children At Risk (Offord, 1989), the Mental Health Needs Of Children In The Care Of Child Welfare (Thompson, 1987), and Promoting The Mental Health Of Children And Youth: A Critical Review Of Recent Literature (Ledingham and Crombie, 1987).

4.2 Overall Prevalence Of Mental Disorder In Children And Youth

It is important at the outset to recognize that mental disorder is but a single element within a much larger set of interconnected factors which together determine mental health status. Based on recent studies the prevalence, or number of existing cases, of all mental disorders (i.e. medically diagnosed illnesses) in the general population ranges between 5 and 30%. The overall rates of prevalence of childhood mental disorders are reported to be in the same range as that for the population at large. For example, a recent study by Offord (1989) found an overall prevalence rate of psychiatric disorders in 3000 Ontario children to be 18.1%.

4.3 Specific Findings Related To Prevalence Of Mental Disorder In Children And Youth

In the Mental Health Status Of Children In Canada and Promoting The Mental Health Of Children And Youth: A Critical Review Of Recent Literature papers, a number of specific findings related to prevalence of mental disorder in children and youth are reported. In general, findings appear to indicate that prevalence rates of mental disorder appear to be higher for older (adolescent) than for younger children, and that the rate of mental disorders in boys exceeds the rate in girls. Offord (1989) reported prevalence rates of psychiatric disorder were highest for adolescent girls (18.6%) followed by adolescent boys (16.8%), 6-11 year old boys (15.6%) and 6-11 year old girls (8.6%). Prevalence rates also appear to be higher for children

living in an urban environment (16.7% from the Offord study) than for those living in rural areas (12.3% from the Offord study), and higher among children from a low socioeconomic class than among those with middle or upper class background.

There are also indications that prevalence rates of various social problems which are correlated with mental disorders are much higher among Native than non-Native populations. These findings, together with the growing awareness of the needs of an increasingly culturally diverse population in Canada, draws our attention to cross-cultural mental health issues.

While most prevalence studies deal with childhood mental disorders from an overall perspective, a limited number of studies have categorized their data by type of disorder (i.e. behavioral, neurotic, and psychotic). The most notable of these findings indicate that:

- behavioral disorders (e.g. conduct disorders, attention deficit disorder) are a more frequent abnormality of childhood than neurotic disorders;

- conduct disorder (e.g. aggression, antisocialization) appears to be the most prevalent form of specific childhood disorder, and is much more common in boys than in girls;

- attention deficit disorder (e.g. impulsivity, hyperactivity) is an extremely common form of mental disorder in children, with boys outnumbering girls.

Additional specific findings indicate that about one third of all children with mental disorders show some form of neurotic disorder, defined broadly as relatively enduring or recurrent symptoms of distress which the individual recognizes as unacceptable and alien to their self. Neurotic disorders are more common in girls than in boys. On the other hand, the rate of prevalence of childhood psychotic disorders (e.g. schizophrenia) is reported to be not more than 0.1%, and are male predominant.

The different types of mental disorder also differ in prognosis. Notable findings suggest that the highly prevalent conduct disorders have a relatively poor prognosis in that 50% of children with conduct disorder will continue to have problems into adulthood. Many of these children will also manifest depression, alcoholism, drug abuse, suicidal tendencies and

psychosis (for a discussion of substance abuse in children and youth, see Substance Abuse By Children And Youth, a paper prepared by Turanski [1988] for the Working Group). Evidence also suggests that children with attention deficit disorder are more likely to display academic problems, alcohol and drug abuse, and contact with the legal system as they grow older. A more negative prognosis for adult mental health is also reported for children with both neurotic and psychotic disorders.

There are also some differences among the types of disorder and those children with the disorder who receive treatment. For example, virtually all psychotic children receive treatment while only a minority of non-psychotic children receive treatment. Those children least likely to receive services are those who do not exhibit overt behaviour problems. In terms of services utilization, it is important to note that there is a significant gap between the number of children identified in epidemiologic studies as requiring mental health services and the number receiving these services. It has been estimated that only a small percentage of children with mental health problems ever receive treatment from mental health professionals. Utilization of mental health services has been found to be related to several variables including type of disorder, severity of symptoms, parents' perception of child disorder, mothers' education and health, and geographic area.

4.4 High-risk Groups Of Children And Youth

As defined in Striking a Balance, mental health "...is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality." (p. 7). Furthermore, "No longer is mental health conceived of as an individual trait, such as physical fitness; rather, it is regarded as a resource consisting of the energy, strengths and abilities of the individual interacting effectively with those of the group and with opportunities and influences in the environment." (p. 7, emphasis added).

In general, the mental health of children is improved in a number of circumstances. Mental health is improved when skills and resources acquired enable children and youth to meet personal needs, contribute to communal life, and improve their environment. Mental health is also improved when a group (e.g. the family or school), acts to support a child, or creates environmental conditions that are conducive to the child's

health. Finally, mental health is improved when society upholds the rights of children and youth, and restrains destructive behaviour. As a result of negative genetic endowment and/or personal, environmental and/or social situations, some children are at higher risk of mental disorder and poor mental health.

Specifically, a number of sociocultural and family factors can pose risks to children's mental health. Sociocultural risk factors include: poverty, minority ethnic status, low social class, parental unemployment, overcrowded housing, and residency in a delinquent neighborhood. Family-related risk factors include: parental psychopathology, deviant patterns of parent-child interactions, and marital discord and divorce. In his study of Ontario children, Offord (1989) found that the most frequently occurring risk factors were one parent families (10.7%), families on social assistance (6.3%), and families from subsidized housing (4.2%).

Finally, some children are at extremely high risk for developing mental abnormality. Included in this group are: children in care of child welfare systems (Thompson, 1986), physically abused and neglected children, victims of sexual abuse, and children from poverty stricken and divorced families.

5.0
CURRENT STATUS OF SERVICE DELIVERY IN CANADA

5.1 Section Overview

The first purpose of this section is to provide a description of Targeted (TAS) and Designated (DAS) Mental Health Services in Canada. The second purpose of this section is to identify and highlight a number of service delivery issues which arise from the manner in which current services are organized and provided to children and their families.

Background information for this chapter is derived primarily from the following sources: Provision of Services to Children With Behavioural or Emotional Problems (Doherty, 1985); Provision of Services to Children With Behavioural or Emotional Problems: An Update of Provincial Services (Campbell and Thompson, 1988); Funding Issues in Children's Mental Health (McLellan, 1988); and Mental Health Services Under The Young Offenders Act (Cyr, 1988).

5.2 A General Description Of Designated Children's Mental Health Services

A report by Doherty (1985), Provision of Services to Children With Behavioural or Emotional Problems, and a recent update of this report (Campbell and Thompson, 1988) provide provincial descriptions of Mental Health Services to children and their families. As well, a report by McLellan (1988) on funding issues also provides background information on the provision of formal and informal mental health services.

While inter-provincial variations in service delivery do exist, the descriptions contained in these reports indicate that there are broad generalities in how mental health services are organized and delivered to children and youth across Canada. In general, the Targeted (TAS) and Designated (DAS) Children's Mental Health System is comprised of the following components:

1) The Community Mental Health System, including Child Guidance Clinics and Mental Health Clinics;
2) Hospitals and institutions;
3) Young Offenders programs;
4) Child Welfare programs;
5) Private practitioners (primarily psychiatrists, psychologists, social workers, and general practitioners).

5.3 Notable Characteristics Of The Formal Mental Health System

Due to the existing inter-departmental structures, the components of the formal Children's Mental Health System typically function fairly independently. While variations exist in some provinces, most notably in Ontario and Quebec (see Doherty report and update), a number of significant general implications for service delivery arise.

The first implication that arises is that services tend to be divided among departments and jurisdictions. As a result, funding for services tends to be on a competitive basis rather than in accordance with an overall strategic plan for service development. As well, service development is fragmented. An example of this is that when a specific need is identified (e.g. child abuse), specific programs are often developed in relative isolation without the recognition and formal mechanisms to account for the fact that there are tremendous overlaps of need between the different specific disorders or mental health problems.

Where fragmentation exists, point of entry into the Mental Health System by children and families usually dictates the nature of longer term service delivery rather than the ongoing needs of the individual child. Furthermore, fragmentation often leads to the need for children to move between system components as their needs and social circumstances change into adulthood. Formal mechanisms to facilitate these necessary transitions are not adequately developed or in place at this time. Clients also contribute to fragmentation by moving around between services, adding to the crises from year to year.

A second implication of the inter-departmental, inter-Ministry, structure of Children's Mental Health Services is that the system as a whole is limited in its ability to self-correct as provincial and community needs change. For example, in most provinces funding for Mental Health Services reflects an imbalance between hospitals and institutions vs. community services, with a vast majority (up to 85% in some provinces) of the funds focused on the former. In the past two decades, however, an increased emphasis has been placed on the need to deinstitutionalize and develop community based programs. Yet because of the existing inter-departmental structure, the funds necessary for community service development are difficult to shift between departments and ministries in order to fund shifts in service delivery philosophy and implementation.

One notable exception to the general structure of Child Mental Health Services discussed above was recently implemented in Ontario with the proclamation of the Child and Family Services Act. This Act now provides authorization for the operation and funding of a number of service categories including Child development service, Child treatment service, Child welfare service, Young Offenders service, Child and family intervention service and Community support service. This recent restructuring of children's services in Ontario represents a major departure which deserves careful observation and consideration as foundations are laid for the development of integrated, effective and efficient Children's Mental Health Services.

5.4 Issues Of Service Delivery and Organization

The primary objective of service organization and utilization mechanisms is to ensure that the right type and level of intervention reaches the appropriate targets. Yet a review of existing formal Children's Mental Health Services brings to light a number of critical issues in addition to those discussed above. The following sections discuss specific issues related to service organization and service delivery.

5.5 Specialist Versus Generalist Orientations

The specialist focus concerns itself with identifying mental disorder, diagnostic specificity and individualized treatment. Essentially, this orientation emphasizes clear cut target populations who have treatable disorders. The specialist orientation within Children's Mental Health Services is best represented by, but not limited to, the profession of psychiatry.

On the other hand, the generalist or generic orientation is much less concerned with specific treatments for specific disorders, but rather seeks to be helpful and caring for a wide range of problems. The inclusiveness of the generic approach often leads to long waiting lists and difficulty in establishing priorities for the most needy.

Both orientations, however, miss the mark in terms of service organization and delivery. While the specialist approach defines need in a fashion which excludes many children whom parents and society deem to require services, the generic approach often fails to deliver because of a lack of clarity about who is in need, and a lack of focus about what or how much can be accomplished in a given situation.

The solution is not to create better definitions to develop an even more exclusive service, nor is it to pretend to be able to

do all things for all people. Rather, the solution which best fits the current state of knowledge about mental health and disorder is to differentiate function within Mental Health Services via a clearer definition of the dual role of formal Mental Health Services. That is, one important role of Mental Health Services is to function as a primary service provider in the prioritized assessment and treatment of mental disorder. The second role of Mental Health Services is to provide leadership in the promotion of mental health through program consultations to allied professionals and workers in the formal children's network (e.g. day care centres, group homes, schools, public health, etc.). In this latter role, the specialized expertise within Mental Health Services can be multiplied throughout the community networks representing the child and family's natural environment.

In summary, the generalist-specialist dichotomy is an inappropriate focus for debate within Mental Health Services. Rather, Mental Health Services for children and youth must focus on a meaningful differentiation of services which are targeted, and delivered, effectively and efficiently to meet priority areas of need within the community with limited resources.

5.6 Hospital Versus Community Services

An effective integration of hospital and community services has not been achieved in child mental health services; consequently, children are less well served than they need to be. One barrier to the effective integration of hospital and community services is that many of the mental health needs of children and youth do not lend themselves to hospital-based acute care services except in life threatening and emergency situations. Furthermore, there is a relative lack of clarity as to which children are of priority need for inpatient care.

Other major barriers are based on the structural organization of health care in Canada in general. For example, the majority of psychiatrists are paid on a fee-for-service basis and practice as solo practitioners, and consultation to others and coordination of services in the community are not recognized in the fee schedule. Somewhat related to this point is the fact that community-based mental health services function on a model which many hospital-based clinicians are not trained to appreciate or value.

Finally, hospitals and community health services are funded by separate administrations, and are not formally organized to work together (e.g. via formal contractual agreements or working protocols). Hospitals are organized to provide acute care services, but tend to function as self-sufficient institutions

which are not responsible for post-discharge care. A major result of these barriers is that the current status of Mental Health Services depends far too much on personal relationships and good will, and far too little on a recognition of the problem and a commitment at all levels of health care administration to a high quality integrated Mental Health Care System.

5.7 Detention and Treatment

In Canada, the various Provincial Mental Health Acts provide for two separate admission procedures for inpatient care. The majority of inpatient care follows a voluntary admission process similar to any other hospital admission. Voluntary admission implies that the person is capable of, and has given an informed consent to the admission and associated treatment. In certain limited circumstances, hospital admission for assessment or treatment can be involuntary if ordered by a magistrate or upon the order of one or more physicians. Involuntary admission follows a finding of severe mental illness and an associated finding of potential danger to self or another person, and carries with it the right to a formal review process if the person wishes to use it.

When a youngster under the age of 16 or 18 (depending upon Provincial law) is admitted to hospital, it is required that a parent or guardian sign the necessary voluntary admission papers. In the voluntary admission of a youngster, there is no review process and consequently, should the youngster disagree, there is no recourse to review or to a second opinion as the admission is deemed to be voluntary because of the parent's or guardian's signed consent. However, the United Nations Convention of the Child states in Article 25:

> "States parties recognize the right of the child who has been placed by the competent authorities for the purpose of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement".

As a consequence, it will be necessary for Provincial Mental Health Acts to be reviewed and changed if Canada is to meet the requirements of the Convention.

Involuntary or mandatory detainment and treatment is also possible through the provision of the Criminal Code of Canada if the person is found to be unfit to stand trial because of mental disorder, or if a person is found to be not guilty by reason of

insanity. However, there are statutory review clauses in the Criminal Code provisions which do not differentialy effect youth.

Mandatory or secure treatment for youth is raised from time to time because parents, guardians or other authorities are convinced that detention is required in order for treatment to be made available. Youngsters, because of their age or immaturity, are often deemed to be unable to make the decision to accept or reject treatment; thus, others would make the decision on their behalf. Care must be taken in drafting mental health legislation, and in conventional practice, to ensure that the provisions of the law allowing for detention for treatment of a mental disorder are not abused in order to detain a young person arbitrarily, in the absence of a mental disorder, because of behaviour which is perceived to be unacceptable.

5.8 Geographic Accessibility

Canada is a vast country with a small population base and, as a result, all provinces except Prince Edward Island have major problems in geographic accessibility. Urban centres across Canada have developed specialized services, and specialist professionals tend to locate in the larger centres. As a result, the many Canadians who live in remote/rural areas do not live in close proximity to hospital or community services, the outcome being that many children from hard to serve areas do not receive treatment or must leave family and home communities to receive services. This is a problem for adults, but an even greater problem for children. When children from remote/rural areas are returned home, follow-up and ongoing treatment are difficult to achieve and coordinate, and the efficiency and effectiveness of services are much reduced. The ever increasing disparity between urban centres and rural/remote communities requires the constant attention of health planners, and creative solutions are required for the future development of children's mental health services.

6.0
FUNDING

6.1 Section Overview

The primary purpose of this section is to present a strategic approach to funding issues for child and youth mental health services. Strategic processes related to funding discussed in this section include planning, priority setting, resource allocation and monitoring of effects. This section also discusses specific funding issues in Canada as derived from a recent provincial survey questionnaire. Finally, options to consider in achieving the goal of enhancing available resources for child and youth mental health are presented. Source documents for this section include: Funding Issues In Children's Mental Health (McLellan, 1988); Investing In Children (Ontario Ministry of Community and Social Services, 1988); and An Overview of Issues and Concerns Related to the Sexual Abuse of Children in Canada (Rogers, 1988).

6.2 A Strategic Approach To Funding

From an operational point of view, funding is essentially an issue of the amount of money available to continue or expand existing programs, and of the use or refinement of funding mechanisms (e.g. approved budgets, purchase of service contracts, service plan). Ultimately, funding drives the services. From a strategic point of view, funding is inseparable from basic questions such as:

- who is providing the funding;
- what is being funded;
- what clients are the recipients and beneficiaries of the service;
- how do the service objectives relate to provincial and national priorities and directions;
- are the results of the service being monitored and evaluated?

6.3 Rationales For A Strategic Approach To Funding

A major rationale for the inclusion of the above questions in a discussion of funding is that the use of public funds is at issue, and that accountability for public funds requires justification at a strategic as well as at an operational level. In allocating public funds to mental health services, it must be ensured that:

- the service is effective;
- the service is economical;
- the service lends itself to health promotion.

A second rationale is based on the knowledge that a substantial gap exists between available resources and service needs for children's mental health services. Given the size of the gap, and given limited public funding, it is neither realistic nor productive to focus funding efforts on the simple additive strategy of getting more dollars to close the gap. Rather, the basic funding issue is two-fold: how can resources be increased, and how can priorities be determined and implemented to ensure the best use of public funds? Clearly, a more planned and strategic approach to funding is required.

A third rationale for a strategic approach to funding addresses the issue of mental health being perceived as a "soft service", and that community skepticism of the effectiveness of mental health services is understandable. Rather than attempt to dismiss this skepticism, a strategic approach to funding would directly address this skepticism through re-examining assumptions, approaches and priorities in the light of the best available information and experience.

6.4 Specific Strategic Funding Issues: Planning And Priority Setting

Studies sponsored by the World Health Organization have come to the general conclusion that mental health services for children and youth are "woefully inadequate" in both developed and developing countries. Through accessibility and utilization data, recent Canadian studies have demonstrated that there currently exists a substantial gap between the prevalence of childhood mental disorder and the availability of resources.

Under the existing health care system the public has access to all professionals in facilities and agencies (e.g. community clinics). Prepaid access to private practitioners is limited to including psychiatrists and other physicians, however, and waiting lists for psychiatrists are often lengthy. While some insurance plans cover partial payment of selected services from psychologists, those wishing to use non- medical private practitioners must in general pay for these services themselves.

From a funding perspective, several related points need to be emphasized about the inadequacy of resources for children's mental health and the need for a strategic perspective.

First, the reality of limited resources must be recognized as a first step in the development of a planning process to both increase resources and use resources most effectively. Second, this planning process must be both credible and effective, ensuring that:

- the purpose and process receive endorsement at the highest levels;
- consumers be represented as an integral part of the process;
- membership in the process reflects the multi-disciplinary and inter-departmental realities of mental health;
- an active information and consultation component be part of the process;
- funding expertise be available throughout the process;
- acknowledged leaders in the field be an integral part of the process.

The third point is that the planning process must function at a strategic rather than a simply operational level by ensuring that planners begin at a level as abstract and as fundamental as values. Having once begun at the level of values, planners would then proceed to principles, strategies, and directions to implement strategies. Finally, the planning process must recognize that while responsibility for social and health services is within provincial jurisdiction, a major objective of planning and priority setting would be to form the foundation for a national federal-provincial approach to the mental health of children and youth.

6.5 Specific Strategic Funding Issues - Resource Distribution, Allocation And Monitoring

A strategic planning exercise will lead to an articulation of values, principles, strategies and directions; it will provide a framework within which children's mental health systems can develop over time. Strategic plans, however, are of little use unless implemented and monitored. It is necessary, therefore, to build into the strategic plan a provision for a subsequent process to operationalize the plan through an organized and credible process of resource distribution, allocation, evaluation and modification.

6.6 Specific Strategic Funding Issues - Inter-System Coordination And Planning

An important characteristic of children's mental health is the extent to which effective service is dependent upon various kinds of inter-system relationships. The interface between the various government departments involved with child and youth mental health (e.g. child welfare, young offenders, education, social services and mental health) represents an important issue from a funding perspective and, consequently, from a strategic planning perspective.

The general point is that the reality of children's mental health as a service system is that most services are delivered by components other than the formal Mental Health System, and that the unique role of the formal Mental Health System is most effectively defined in relation to an inter-system context rather than as a discrete system with its own clientele and professionals, distinct from other children's services. According to Rogers (1988), most provinces and territories have developed inter-departmental committees to deal with specific issues such as child abuse, and have developed either informal or formal inter-departmental agreements to deal with these issues. The fact remains, however, that "Nowhere in the country have these agreements been translated into a comprehensive integrated service delivery system at the community level that is child-centred and that has a complete continuum of specialized resources and services." (p. 100).

Rogers goes on to state that inter-jurisdictional and inter-disciplinary barriers are compounded by serious deficiencies in resources, thus tying the two issues together as a matter of priority importance. To illustrate the potential deleterious effects of these two compounding issues, it is currently estimated that as many as 30% of children who are in care of some provincial Child Welfare systems are there not because of abuse or neglect but because of parental agreement in order to gain access to needed treatment services. From the perspective of funding as a strategic issue, the important point is that the planning process must account for cross-jurisdictional anomalies to ensure services are delivered properly, and certainly to avoid the need for parents to take extraordinary action in order to obtain services for their children.

Given the inter-system realities of mental health services to children and youth, a number of requirements of the planning process become evident. To begin with, a priority question which requires attention is to ask who can do what most effectively within the inter-system context. Secondly, funding

reform should follow principles which would create incentives to reinforce cooperative, collaborative and complementary inter-system services. Finally, it is being suggested that new funding proposals should specifically articulate inter-system linkages, reciprocal agreements with other service providers, and appropriate role differentiation.

6.7 Specific Funding Issues In Child And Youth Mental Health

A recent survey, conducted as part of the Working Group's process, indicates that there are three consistently identified types of funding problems in children's and youth's mental health. The first type of funding problem is the serious inadequacy and lack of resources for children's and youth mental health services. Lack of resources was defined in terms of financial, human and program resources for mental health promotion, prevention, treatment and rehabilitation. Second, lack of federal cost-sharing for mental health services and general funding constraints were cited as major contributors to the lack of resources for children's mental health.

A third funding problem, which is generally viewed to compound the first two, relates to how the limited resources are allocated within the context of not only children's and youth mental health, but within the context of the entire mental health systems as well. While there are variations between the responding provinces, a number of common allocation issues exist. The most common of these issues include:

1. Allocation of resources between adult vs. children's services is problematic in that adult services receive the lion's share of available resources;

2. Inequities within the children's area in terms of the distribution of resources between institutional and hospital based services and community based programs, favoring the former;

3. High levels of funding in specialized areas;

4. Funding through a variety of departments, resulting in problems of coordinated planning, resource allocation and service delivery;

5. While recognizing the high need, undue emphasis on Child Welfare and Young Offenders to the detriment of other children's and youth services.

6.8 Enhancement Of Resources

In view of the current funding inadequacies for children's mental health services, enhancement of resources is a priority. Federal cost-sharing is a key issue for the enhancement of resources for children's and youth mental health services. As a contrast to current funding for mental health, child welfare and young offenders programs have an effective cost-sharing instrument, one which has had an important positive effect on the development of those service systems. The Canada Assistance Plan (CAP) as it now stands specifically excludes health and mental health from the cost-sharing of social services, and the Established Programs Financing (EPF) agreement is not relevant to the goal of achieving access to federal resources for mental health services;

In his discussion paper on the sexual abuse of children in Canada, Rogers (1988) succinctly summarizes the need for a revision of federal/provincial/territorial funding programs. This revision, which is valid within the broader context of children's and youth mental health, must provide at a basic level for adequate mental health treatment and prevention services as well as for the implementation of integrated service delivery systems. Additionally, this revision must also provide for the expansion of the current model of professional service reimbursement, so that qualified professionals are reimbursed for assessment and treatment services. Finally, provision is required for the reimbursement of professionals (currently physicians and psychiatrists) providing mental health services within the broader context of community mental health consultations and service.

As well, there is a need to redress the imbalance in health funding between adult and children's mental health. First, there is a need to establish specifically designated funding for children's mental health separate and apart from funding for adult mental health. Second, there is a need to maintain priority funding for children's mental health.

Finally, a generally accepted principle in the health and social service fields is that non-residential treatment and care is less intrusive, less costly, and more conducive to early and preventive intervention than residential inpatient treatment and care. The current strong interest in this regard in many jurisdictions highlights the importance of funding initiatives for mental health promotion, prevention and early intervention.

7.0
SERVICE LINKS AND PARTNERSHIPS

7.1 Section Overview

The first purpose of this section is to present an inventory of resources, and a description of the capacity of these resources, to influence the mental health status of children and youth in Canada. The second purpose of this section is to discuss the need to strengthen collaborative and cooperative partnerships in child mental health services in order to develop an effective and efficient continuum of child mental health resources and services. Parts of this discussion are based on the paper Ingredients Toward A Philosophy Of Service Delivery To Children (Cyr, 1988), prepared for the Working Group.

7.2 Formal Child And Youth Mental Health Services

In the formal Mental Health systems there are two streams by which services have developed: (1) Child and Adolescent Psychiatry; and (2) Child Guidance Clinics. Child and Adolescent Psychiatry has developed as an extension of the adult psychiatric model, and is based on fee-for-service payments to medical practitioners through medical care plans and the use of inpatient hospital care generally for acute treatment. Child Guidance Clinics have developed with a broader social systems basis, use a variety of professions, are ordinarily funded by governments, and have tended to focus on counselling parents and consulting to schools and other community care-givers. Neither approach alone is sufficient, and the two approaches have tended to compete for resources and supremacy.

7.3 Primary Care Physicians (UAS)

Primary health care providers such as general practitioners are often the first point of contact for children and youth at risk. Estimates are that 40-60% of visits to physicians reflect an emotional rather than physical problem (Cummings, 1985). Yet many primary care physicians are neither trained, nor have the specialized skills, to provide mental health services. Consequently, close liaison between primary care physicians, mental health professionals, and mental health services is necessary.

7.4 Public Health Services

Public Health Services are responsible for two programs which influence the mental health of youngsters: (1) Child and

Maternal Health (Early Childhood Services); and (2) School Health Services. Early Childhood Services include parental education and care, home visits, Child Health Clinics, health screening and appraisal, parent counselling and referral as mainstays of the child health program.

School Health Services monitor child health, provide direct services and referrals within the health system, advise schools about good health practices, link with other health resources, and encourage good health learning.

There are three major structural problems which have limited the potential effect of the Public Health programs where Mental Health is concerned. First, there are insufficient mental health resources to respond to all concerns and referrals made by public health. Second, the two systems have not been well coordinated even though they are almost always within the same provincial ministry. Third, the formal Mental Health Services have tended to respond to crisis care rather than allocate resources in a more planned manner to provide early identification and intervention.

Public Health has near universal accessibility to young children and parents in the community. Because of this, the relationship between Mental Health and Public Health is essential to develop (Roberts, 1984, The Alberta Public Health Liaison Project) to encourage continuity of care, mental health promotion, prevention, early identification of children at risk, and early intervention.

7.5 The Educational System (UAS)

After parents and family, the school has the most significant impact upon the development of children. Within the educational system there are three types of "special services" specifically relevant to mental health services: (1) school guidance counsellors; (2) school psychologists and social workers; and (3) specially trained teachers in special education classes.

The mental health services which schools provide are a great potential asset which must be developed. However, there remain a number of critical barriers to services to children within the educational system for which schools require additional support. First, there is the sometimes lingering social perception that children, or parents of children, with mental health problems and behaviour disorders are somehow to blame. Compounding this perception is the additional perception that schools are responsible for teaching employable skills, and that family life, emotional health, and conflict resolution are the sole

responsibility of the parents. While schools can not be expected, nor do they have the resources, to directly solve home and family problems, there is a clear need to develop and reinforce the concept of multi-disciplinary, cross-system teams working in formalized partnerships to meet the needs of children and families. A final barrier to services to children in schools is that youngsters who drop out of school are out of the orbit of formal education, and many of these are at greatest risk for mental health problems.

Because schools have legislated universality of access, they have the greatest potential capacity for impact on the mental health of children and youth. For this reason, it is important that Mental Health Services be organized and funded in such a fashion that schools can be maximally influenced and supported.

7.6 Alcohol And Drug Services

Provincial services directed to the problems of alcohol and drug abuse are separately administered from formal Mental Health Services. However, there are many important similarities when the mental health of children and youth is the central question. For example, children who grow up in homes where alcohol and drugs are major problems are at high risk for developing mental health problems, and children and youth who abuse alcohol and drugs themselves have problems in all areas of their lives. Due to these significant overlaps in problems, Mental Health Services must work closely with Alcohol and Drug Services in order that services are planned and effective, that there is coordination and consistency, and that there are no gaps in services provided.

7.7 The Child Welfare System (MAS)

The primary mandate of the child welfare system is to protect and care for children in situations where parents abuse and neglect children, or otherwise default on their responsibilities. Over the past two decades, the child welfare system in Canada has provided the majority of mental health services available to children and youth outside the realm of formal Mental Health Services. Surveys have found that between 60-80% of children in the Child Welfare System have emotional or behavioral disorders, regardless of the reason they entered the system. These figures illustrate that children in Child Welfare are one of the highest identifiable risk groups for mental illness. Adequate resources must be made available for their treatment.

As mentioned earlier, it is estimated that as many as 30% of children placed in care are in this status not because of abuse or neglect but because of parental agreement so to gain access to

needed treatment services. This fact speaks loudly not only to the need to avoid the understandable (from the child and parent's perspective) but improper use of services and the need for increased mental health resources, but most importantly to the need for effective and efficient collaboration and coordination between Child Welfare and Mental Health.

7.8 The Young Offender System (MAS)

As a result of the implementation of the Young Offenders Act in 1984, more youngsters are receiving mental health services through this system, and the services are better differentiated and more specialized. The Young Offenders Act recognizes "the special needs" of the offender, and relies on specifically trained professions in the assessment and remediation of youngsters with developmental and psychological problems.

To meet these needs, there has been an increased reliance on mental health services and personnel which has allowed for a planned increase in mental health services for children and youth coming under the jurisdiction of the Act. This increase is significant in that youngsters with behavioral problems or conduct disorders have not been a high priority within the formal Mental Health Service prior to this time.

7.9 The Need For Partnership In The Provision Of Mental Health Services

Formal Mental Health Services for children and youth are essentially reactive to the needs of youngsters already in crisis and, due to a lack of funding as discussed in the previous chapter, focus their services on those with severe and chronic disorders. Consequently, due to limited and specialized program resources, access to formal Mental Health Services is relatively restricted. Furthermore, and compared to prevalence rates for mental health disorders in children and youth, utilization rates are low for formal Mental Health Services.

On the other hand, many other components of the total children's mental health services system in Canadian communities, while they respond to youngsters already in crisis, have the capacity to be more proactive through mental health promotion, prevention, early identification and intervention. Access is virtually universal in some (Education and Public Health), and mandated by legislation in others (Child Welfare and Young Offenders).

A major dilemma exists between components of the total children's services system. That is, while formal Mental Health Services have a greater concentration of specifically trained and specialized resources, other tiers and components of the total system have greater access to children and youth, and greater opportunity to provide mental health promotion, prevention, early identification, early intervention and treatment.

In terms of mental health resources, all components and tiers of the total children's services system are currently insufficiently funded. It would not be practical, nor would it be productive, to attempt to develop both the formal and informal mental health system to a level where each could provide comprehensive mental health services. Rather, due to the realities and potentialities of access and utilization, the total system must be strategically developed and funded in an integrated fashion so as to provide a collaborative and coordinated continuum of mental health resources and services.

An important key to the provision of collaborative and coordinated mental health resources and services is effective liaison across all levels of mental health care. Liaison can be divided into three types, with each type being necessary for integrated services. The three types of liaison are:

1) Communication liaison - exchanging knowledge about services in general, or what may be available to assist a particular client;

2) Coordination liaison - meeting with other agencies to plan services so that they not overlap nor leave major needs unmet;

3) Consultative liaison - providing expertise for the purpose of teaching, supervision, assisting in assessment or making decisions in management, therapy, evaluation or research.

Finally, it is critical that the family and children be recognized as essential partners in the provision of mental health services. Without the full participation of these consumers, mental health services will find the task of integration to be extremely difficult. The processes of planning and development of coordinated mental health services should not only include, but should encourage the input and participation of families, children and youth.

7.10 Recommended Actions To Integrate The Formal Mental Health System

The horizontal and vertical integration of the formal Mental Health Services is a prerequisite to high quality children's mental health care. To date, there has been separate development of the component parts of what should form the basis of a comprehensive service system. The integration of these services and their mutual influence on the mental health problems of children and families is required. Pragmatic steps to unite the forces available through the hospital systems, the child guidance and mental health clinics, and longer term residential treatment services could include:

1. Allowing referrals from designated mental health facilities to psychiatrists in private practice;

2. Allowing psychiatrists to bill health care plans for non-clinical activities such as consultation and coordination meetings within the community;

3. Assuring budgets are available to have psychiatrists provide clinical consultation in the mental health facilities;

4. Consideration for the creation of health care coverage for assessment, treatment and consultation services by clinical psychologists and social workers; community mental health nurses and other mental health workers (i.e. increased funding for public services);

5. Developing formal mechanisms (e.g. via contractual agreements) for local outreach consultation services from specialized hospital and residential programs;

6. Systematic involvement of local service providers when youngsters are placed away from the home community to receive specialized assessment or treatment;

7. Establishing formal mechanisms to provide leadership and focus the integration of mental health services system;

8. Encouraging inter-disciplinary training and involving the students in internship experiences in the various component parts of the service delivery system.

7.11 Recommended Actions To Develop Partnerships Within The Total Children's Mental Health Services System

Child and Youth Mental Health Services should seek to collaborate with the overall child-caring system rather than replace it in the name of Mental Health. The principle of normalization is basic to the mental health of youngsters; however, in order to act upon this principle it is necessary to organize mental health services in order to serve other sectors in the overall child-caring system within the community.

Youngsters with special needs can be provided services effectively and efficiently in day cares, schools and through other community service organizations to the extent that there is a collaborative and cooperative partnership with formal Mental Health Services and the components of the total children's services system. Child and youth Mental Health Services should seek partnerships with parents and local service providers which emphasize mental health promotion, prevention, early identification, and multidisciplinary intervention planning in the most cost effective, and least restrictive, manner.

8.0
RESEARCH IN CHILDREN'S MENTAL HEALTH

8.1 Section Overview

The purpose of this section is to state the need for research in the area of children's mental health, and to indicate a number of research priorities. This section is based on Research Priorities for Children's Mental Health (Thompson, 1988), prepared for the Working Group.

8.2 The Need For Research In Children's Mental Health

Children's mental health is currently under-represented in regard to research funds on a national level. The Medical Research Council and Health and Welfare Canada dedicate approximately 4.3% of their research grants towards mental health in general, of which only 16.8% are geared towards children's issues.

There are a number of compelling reasons why there needs to be increased research into childhood disorders and mental health. To begin with, mental illness is the most prevalent form of illness, and children have as high a prevalence and incidence of emotional and behavioral disorders as does the general population. Furthermore, children's disorders may, and often do, develop into adult mental health problems later in life. Consequently, studies could provide preventative measures guarding against subsequent adult disorders through the identification of children at risk. Thus, research on children could reasonably be expected to be over-represented in the mental health area.

To date, existing research on children's mental health issues has focused primarily on academic or theoretical problems rather than on applied issues such as those arising from clinical service delivery. As well, the majority of research conducted into children's mental health has been cross-sectional in nature; that is, the studies have generally been limited to examining questions at a fixed point in time. Given that many psychological disorders are established over a gradual time period, greater emphasis should be placed on longitudinal projects. Information from longitudinal studies would enable clinicians to identify those children at risk for emotional disorders, as well as allow for the development of proactive service delivery systems.

8.3 Recommendations For Research Into Children's Mental Health

Given the current situation in Canada, it is possible to make a number of recommendations for research into children's mental health. Most importantly, increased funding is required for research on childhood disorders, as well as on childhood behaviour that may lead to adult disorders. Some of this increased funding should be given to studies of questions and issues which stem from applied problems and to research conducted in applied settings. Finally, research should be funded in accord with the following priorities:

1) Epidemiological analysis of the incidence and prevalence of childhood disorders, with a view to identifying risk factors;

2) An examination of "invulnerable" (i.e. healthy) children to establish factors that may predict emotional/behavioural stability;

3) Longitudinal/prospective studies of high-risk children in order to determine the extent and nature of later mental health problems;

4) An examination of the effects of social factors (e.g. poverty, ethnicity, minority status, familial structure) and their impact upon the mental health of children;

5) Studies, including pedigree analysis, linking biological (genetic) phenomena to emotional/behavioural disorders;

6) Evaluation of existing programs serving children with emotional/behavioural problems including children's psychiatric units;

7) The development of large scale longitudinal methodologies to evaluate the effectiveness of preventive interventions;

8) The development of standardized tools for measuring childhood emotional/behavioural disorders;

9) The development of standardized classification of childhood emotional/behavioural disorders.

9.0
TRAINING OF CHILDREN'S MENTAL HEALTH PROFESSIONALS

9.1 Section Overview

The purpose of this section is to present a potential framework for the training of children's mental health professionals. Source material for this section is derived primarily from A Guide to Knowledge and Skills Necessary for Employment Within a Mental Health Service (1983).

9.2 Knowledge And Skill Requirements In Children's Mental Health

As developed earlier in this report, the broader definition of mental health to include not only mental disorders but factors involved in the interactions between individuals, groups and the environment implies that knowledge and skill requirements of persons working in the area of mental health be addressed at a broader level as well. While it is possible to speak of specialist and generalist orientations in the field of children's mental health, and while it is recognized that each orientation will emphasize different skills and knowledge, the fact remains that there exist over-lapping training needs. These over-lapping training needs exist primarily from the perspective that there is an increased need to develop functional partnerships and linkages between and among all components and tiers of the total.

Currently, there are wide variations in the knowledge and skills of all persons working all components and tiers of the total children's mental health services system within the area of children's mental health. Some of these variations are due to the broad range of specializations which exist in all components of the total mental health systems, ranging from psychiatrists and physicians, to psychologists, social workers, psychiatric nurses, occupational therapists, public health nurses, teachers and child care workers. Intra-professional variations also exist, and are in part due to differences in training programs between colleges, universities and other educational programs in Canada and abroad. Finally, variations between professional associations also exist in terms of accepted clinically-based criteria for accreditation or licensure.

In view of these variations, and to address training issues in the field of mental health in general, the Provincial and Territorial Mental Health Directors developed A Guide To Knowledge And Skills Necessary For Employment Within A Mental Health Service. The principles put forth in this guide are

instructive for the consideration of training requirements for basic competencies within both formal and informal mental health systems, and are presented in the following sections.

9.3 Basic Competencies - All Professionals

Basic competencies for all professionals providing direct client mental health care are classified into those required in terms of knowledge and skill-based training in psychosocial skills, and those required in terms of job requirements. Basic competencies in terms of knowledge and skill-based training in psychosocial skills include the following:

1) A general knowledge of "syndrome psychiatry";
2) A general knowledge of child development and of physical, psychological and social models of distress and disease;
3) A general knowledge of family phases of development and of physical, psychological, and social therapeutic modalities;
4) A more specific knowledge of at least one particular model of both distress and treatment;
5) A knowledge of personal limits;
6) A knowledge of area resources and how to utilize them;
7) Skill in establishing a therapeutic relationship;
8) Skill in interviewing;
9) Skill in conceptualizing and formulating the problem while taking multiple areas (physical, psychological, social) of functioning into account;
10) Self awareness (e.g. skill in recognizing self interests and biases);
11) Skill in knowledge acquisition (Self-education) and knowledge distribution (Other-education).

Basic competencies in terms of job requirements include: (1) assessment procedures and objectives; (2) formulation and priorization of problems; (3) intervention planning; (4) documentation; and (5) case management.

9.4 Basic Competencies Within Separate Professional Categories

Some professions not normally recognized as "mental health professions" bring their own specialized knowledge and skill to bear on children's mental health programs. These "related professions" may include teachers, speech therapists, clergy, recreational specialists, etc. While members of related professions do not necessarily need all the basic competencies listed above, it is suggested that these persons must be able to demonstrate a number of general ability characteristics. For

example, professional skills must be practiced in a disciplined manner. That is, related professionals must be aware of deviations from generally accepted forms of practice and must be able to regulate their behaviour so that it meets guidelines for acceptable practice. As well, professional skills must be practiced in a way which shows respect for the individuality of the child.

It is suggested that competencies are required of mental health professionals above and beyond those listed in Section 9.3, and in addition to their training in their own discipline. These additional competencies include: (1) specific training and/or post-graduate experience in relevant clinical work: (2) the ability to make a contribution to assessment, diagnostic and treatment processes; and (3) provincial registration or licensing where appropriate.

10.0
FOUNDATIONS FOR THE FUTURE: THE BUILDING BLOCKS

The mental health and well-being of children and youth is influenced by two primary factors: personal vulnera-bility to mental disorder, and environmental factors. Epidemiological research has shown that up to 30% of youngsters are affected by mental disorder during the childhood years and that countless others are at risk due to factors such as disrupted family relationships, poverty, physical and sexual abuse, and alcohol and drug abuse. Furthermore, it is disturbing to note that many children do not "grow out of a problem" as is often believed. Rather, they grow out of the childhood symptoms while the underlying problem remains into adulthood. Consequently, the enhancement of positive early experiences, as well as prevention and early intervention during childhood are critical for the development of healthy underpinnings of adult mental health.

Children currently make up approximately 30% of Canada's population. Canadian children and their families have a right to the highest standard of health and health care facilities as affirmed by Canada's sponsorship at the United Nations, of the Convention on the Rights of the Child. To compromise their right to health is to compromise Canada's future, for these children and youth truly represent the foundations for our future. Yet Canadian studies have demonstrated that there exists a substantial gap between the prevalence of childhood mental disorder and the availability of resources, that the majority of children with mental health problems never receive treatment from mental health professionals, that many families and children have limited access to fragmented services, and that many other families must resort to extraordinary measures to obtain services for their children.

In fulfilling the objectives assigned by the Federal/Provincial Advisory Committee on Mental Health, the Federal Working Group on Child and Youth Mental Health recognized that there were many issues involved in and influencing the current mental health status and future mental health needs of Canada's children and youth. What follows is a summary presentation of four major building blocks, each representing central ideas and directions which, taken together, form the foundation for change and innovation needed for the future. The building blocks accommodate the wide inter-provincial diversity in mental health services, while at the same time recognizing the need to develop a comprehensive national strategy to implement mental health services to meet the specific and unique mental health needs of our children and youth.

10.1 Mental Health Promotion

Health is a state of complete physical, mental and social well-being and not merely the absence of disease:

- Mental health is promoted when the family is strengthened in its child-caring role and in its capacity to provide the environmental conditions conducive to health;

- Mental health is promoted when society recognizes and provides for the changing developmental needs of youngsters from infancy to adulthood;

- Mental health is promoted when children acquire skills and resources that enable them to meet personal needs, to contribute to family and community life, and to improve their environment.

Most adult mental health disorders have their antecedents in early identifiable childhood problems; consequently, prevention and early intervention activities are critically important:

- Prevention involves the promotion and maintenance of good health through education, attention to adequate standards for basic needs, and specific protection against known risks are needed;

- Critical preventive and early intervention services including the development of close links between mental health, public health and education services and programs are a high priority;

- In the transitional stage from youth to early adulthood, stronger ties are required between mental health, advanced education, training and employment services and programs.

Policies and strategies are required which support the promotion and protection of mental health within the community;

- Highest priority must be afforded those aspects of health policy which strengthen the capacity of families to provide for their children at home.

- Healthy public policy in local communities which supports the mental health of children and youth is required; housing, play, policing, hospitals and schools are highest priority;

- Locally available family-centred treatment and care is less intrusive, less costly, and more conducive to long lasting results than residential inpatient treatment and care.

10.2 Partnerships

The mental health and well-being of children and youth is the shared responsibility of children themselves, their families and society:

- The role of health consumers is rapidly shifting from traditional passivity to active partnership with the service providers;
- There is a need to recognize and promote the central role of the family in the services partnership;
- Children who are capable of forming their own views have the right to express those views freely in all matters.

Collaborative and cooperative partnerships in child mental health services need to be strengthened via:

- Effective liaison across all types of services for children and families;
- Increased integration of specialized Mental Health programs with community programs and resources;
- Integration of residential, hospital and community mental health systems;
- Developing stronger relationships between Mental Health, Public Health, Education, and Recreation;
- Consultation and coordination with the child protection, young offender and alcohol and drug service sectors;
- Effective partnerships with representatives of culturally diverse and Native populations in Canada;

- Formalized, contractual agreements between collaborating and cooperative service providers;

- Policy and funding reforms which would remove barriers and create incentives to reinforce cooperative and complementary inter-system services.

Consultation models of service provision need to be reinforced and expanded:

- Specialized mental health expertise can be multiplied through program consultations to allied professionals, programs and services.

- Strengthening local community services through joint programs with schools is preferable to developing highly specialized, segregated mental health services.

10.3 Access

Access to services for children and their families should be simplified and sensitive to their needs. By co-sponsoring the United Nations Convention on the Rights of the Child, the Government of Canada has reaffirmed that every Canadian child has a right to the highest attainable standard of health and health care facilities, and access to such health care services:

- Because access to health is largely determined by the child's family, efforts must be made to ensure that parents have the health knowledge and resources to recognize and plan family health matters;

- Highly accessible systems such as Education and Public Health must be supported in their capacity to provide preventive education and health promotion services and cooperative programs developed with Mental Health to provide for those who are identified as at risk;

- Mental health must make available services which are responsive to and reflect the increasing cultural diversity of Canada's population and, as a highest priority, provide appropriately for Native Indian children and families both on and off reserves.

There is a significant gap between the number of children identified in epidemiologic studies as requiring mental health services and the number receiving these services:

- Only a small percentage of children with mental health problems ever receive treatment from mental health professionals; thus, effective screening, referral and linkage mechanisms are required to ensure those most in need are provided for;

- The vast majority of children, including those at highest risk for mental health problems, visit their family doctor regularly, thus, training and referral consultation is a high priority for Mental Health Services;

- Access to appropriate services is possible only if there are proactive programs available for high risk children and families. ("Nobody's Perfect", a program developed in the Atlantic provinces, is a successful prototype);

- The transitional status of 16 - 19 year old youth often leads to problems (of access to, and occasional abuse of services) which require special planning of appropriate referral and consultation mechanisms;

- The majority of youngsters in the mental health system are the highly visible and volatile youth in conflict with family and community. Special Services and access routes are required for infants and young children and those yougsters who withdraw and internalize problems, e.g. those with depression and schizophrenia.

Due to limited program resources, access to formal Mental Health Services is relatively restricted:

- There is an increasing disparity in access to services between urban centres and rural/remote communities which requires that locally available services be initiated which are linked to the specialized services for consultation;

- The manner in which services are organized and funded, including Federal/Provincial cost-sharing agreements, requires review and revision to remove structural barriers to planning and delivering appropriate services;

- Parents often need to take the extraordinary action of placing their child in the care of the child welfare authorities to gain access to appropriate, specialized services, a situation which requires formal review and appropriate alternative mechanisms such as linked referral systems.

10.4 Innovation And Excellence

A strategic planning process is required to provide a framework within which children's mental health systems can develop and meet changing needs now and in the future;

- Consumer involvement at all levels of the planning process is essential;

- The planning process must begin at a level as fundamental as values and social expectations; planners would then proceed to articulate principles and policies to govern the delivery of programs;

- The planning process must include provision for organized and credible processes of resource distribution and allocation, program evaluation, and program modification;

- Greater coordination of the overall child and youth serving systems is required and a comprehensive restructuring of children's services deserves careful consideration as foundations are laid for the development of integrated, effective and efficient children's mental health services.

Accountability for limited public funds requires justification at a strategic as well as at an operational level:

- Allocation of public funds to mental health services requires a strong commitment to program evaluation to ensure that services are effective, economical, and lend themselves to health promotion;

- Funding strategies must be responsive to changing needs, shifts in service priorities, and the emergence of new challenges.

There is an increased need for research into childhood disorders and mental health:

- More resources need to be devoted to research on children's emotional disorders. Funds should be increased until the research budgets for children's disorders match the representation of children in the population (e.g. if children make up 20% of the population, then 20% of mental health research funds should be devoted to children);

- The funding of research into children's disorders should also be based on priorities that will lead to improved treatment, better service delivery, and perhaps most importantly, to the prevention of mental illness and its consequences. The recommended priorities in section 8.3 should be debated and altered from time to time as the service delivery system changes;

- More research should take place in applied settings, as opposed to academic settings, in order to focus research projects towards better service delivery and treatment.

Pre-service and continued professional training:

- An ongoing partnership among mental health, the professions and the colleges and universities is needed to meet future training requirements;

- A linked system of ongoing inter-disciplinary training and consultation is required to support the increasingly differentiated service delivery system;

- Changes in mental health knowledge and practice imply that personnel in the broader fields of child and family services be afforded the opportunity to learn and apply new knowledge and skills.

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APPENDIX

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During the development of the Report, significant contributions were made by Provincial representatives whose term of office ended prior to its completion. Names of all participants are listed.

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